Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 24, 2019	2019_766500_0018	012878-19	Critical Incident System

Licensee/Titulaire de permis

The Rekai Centres
345 Sherbourne Street TORONTO ON M5A 2S3

Long-Term Care Home/Foyer de soins de longue durée

Wellesley Central Place
160 Wellesley Street East TORONTO ON M4Y 1J2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

NITAL SHETH (500)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 8, 9, 10, 17, 18, 2019.

The intakes log # 012878-19, (CIS #2959-000009-19) related to unexpected death was inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing (DON), Resident Assessment Instrument (RAI)- Coordinator, Registered Dietitian (RD), Registered Nurse (RN), Coroner Officer, Personal Support Workers, (PSWs), Substitute Decision Maker (SDM) and Private Sitter.

During the course of the inspection, the inspector observed a meal service, staff to resident interactions, residents' care areas, reviewed residents' health records, and the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #001 collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A review of Critical Incident System (CIS) report indicated that resident #001 had an unexpected death on an identified day. The resident was found unresponsive after a meal. As per the coroner, the cause of death was undetermined until the investigation is completed.

A review of the resident's written care plan indicated that the resident has a specified issue during eating. There was no intervention developed in the care plan to address the resident's issue. On the same day when this care plan was initiated, a referral was sent to Registered Dietitian (RD) about a different issue, however this referral did not include any information about the resident's specified issue during eating.

During an interview with Registered Nurse (RN) #102, they were not able to explain a reason for not sending a referral to the RD about the resident's specified issue while eating.

Interview with RD indicated that they were not aware about the resident's specified issue

while eating. RD indicated that they would have expected a referral from nursing for the resident's specified issue.

Interview with RAI-Coordinator and Director of Nursing (DON) indicated that the referral should have been sent to RD for the resident's specified issue while eating and plan of care should have been based on the resident's interdisciplinary assessment.

The inspector issued this non-compliance as a result of the nursing failure to collaborate with RD to address the resident's issue with the specified issue while eating. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #001.

A review of Critical Incident System (CIS) report indicated that resident #001 had an unexpected death on an identified day. The resident was found unresponsive after a meal. As per the coroner, the cause of death was undetermined until the investigation is completed.

A review of progress notes indicated that the resident was seen by Personal Support Worker (PSW) #103 at an identified time who brought them the food tray and the resident looked at the PSW #103 and said, "thank you". At approximately an hour later, PSW #104 passed by in the resident's room and noted them sleeping. RN #102 came to assess the resident at about one hour later as received a report that resident did not eat. RN #102 noted the resident unresponsive.

A review of the resident's written care plan indicated that the resident required safety check every 15 minutes. The resident had a specified issue while eating. The resident required supervision for eating related to physical limitations. The resident's Substitute Decision Maker (SDM) signed for allowing the resident to eat by themselves in their room despite the risk. Staff to approach and reapproach the resident to encourage them to eat at meal times. The care plan indicated that the resident was receiving an identified food texture food, and staff to implement an identified intervention.

A review of the video footage provided by the resident's family member indicated that on the day when the resident passed away, PSW #103 provided a food tray to the resident and left the room at a specified time. The resident took a quarter piece of a food item and put it in their mouth. The private sitter arrived at the resident's room to collect their charger at a certain time. The RN arrived at the resident's room for an assessment at the

same time.

A review of a picture of the resident's food tray provided by the RN #102 and DON shows that the identified intervention had not been implemented.

Interview with the resident's family member indicated that they thought that the resident passed away from choking on food and requested for investigation.

Interview with PSW #103 indicated that after completing service in the dining room, they served a tray to the resident. They set up the tray for the resident at bedside and told the resident, that its their favourite meal, and the resident said, thank you to the PSW #103. PSW #103 indicated that the food item was cut into four pieces.

Interview with PSW #104 indicated that they provided morning care to the resident and then after seeing the resident sleeping at around an hour later from when the food was served to the resident. PSW #104 indicated that they kept the resident's door open so staff passing by in the hallways can see the resident.

Interview with a private sitter indicated, they went in the resident's room after the meal. The resident was sleeping in their bed and RN #102 was assessing the resident at that time. They left the room and later heard that the resident passed away. Once the family arrived, they called the private sitter, and they were trying to find out a reason for the resident's death. They saw the resident's mouth and saw food in their mouth. Private sitter indicated that they think, that the resident passed away because of choking by food.

Interview with RN #102 indicated that PSW #104 reported that the resident did not eat and therefore, they went into the resident's room for an assessment. Upon assessment, they found the resident unresponsive.

The interview with RN #102, RAI- Coordinator and RD confirmed that the resident did not receive the identified intervention. RN #102 and RAI-Coordinator confirmed that the resident required every 15 minutes safety checks. RD confirmed that as per the plan of care the resident required encouragement for meals, and the identified intervention should have been implemented. .

PSW #103, #104, RN #102, RAI-Coordinator, RD, and DON confirmed that staff are expected to follow the resident's plan of care.

The inspector issued this non-compliance as a result of the staff failing to:
-follow the resident's plan of care in terms of every 15 minutes safety checks for one hour,
-provide the identified intervention and
-to approach and reapproach during meal time to encourage the resident to finish their meal as indicated in their written plan of care. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 25th day of July, 2019

[redacted]

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NITAL SHETH (500)
Inspection No. / No de l'inspection :	2019_766500_0018
Log No. / No de registre :	012878-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 24, 2019
Licensee / Titulaire de permis :	The Rekai Centres 345 Sherbourne Street, TORONTO, ON, M5A-2S3
LTC Home / Foyer de SLD :	Wellesley Central Place 160 Wellesley Street East, TORONTO, ON, M4Y-1J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sue Graham-Nutter

To The Rekai Centres, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6. (7) of the LTCHA, 2007. Specifically, the licensee must do the following:
1. Any resident requiring assistance with setting up their meals including cutting food into bite-sized pieces receive that assistance as identified in the plan of care.
2. Any resident who require safety checks to be conducted every 15 minutes will receive the checks as identified in the plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #001.

A review of Critical Incident System (CIS) report indicated that resident #001 had an unexpected death on an identified day. The resident was found unresponsive after a meal. As per the coroner, the cause of death was undetermined until the investigation is completed.

A review of progress notes indicated that the resident was seen by Personal Support Worker (PSW) #103 at an identified time who brought them the food tray and the resident looked at the PSW #103 and said, "thank you". At approximately an hour later, PSW #104 passed by in the resident's room and noted them sleeping. RN #102 came to assess the resident at about one hour later as received a report that resident did not eat. RN #102 noted the resident unresponsive.

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The resident required supervision for eating related to physical limitations. The resident's Substitute Decision Maker (SDM) signed for allowing the resident to eat by themselves in their room despite the risk. Staff to approach and reapproach the resident to encourage them to eat at meal times. The care plan indicated that the resident was receiving an identified food texture food, and staff to implement an identified intervention.

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-follow the resident's plan of care in terms of every 15 minutes safety checks for one hour,
-provide the identified intervention and
-to approach and reapproach during meal time to encourage the resident to finish their meal as indicated in their written plan of care.

The severity of this issue is a level 3 (actual harm), the scope was a level 1 (isolated), as it related to one out of three residents reviewed, and compliance history was a level 3, previous noncompliance to the same subsection of the LTCHA that included Written Notification (WN) issued during Inspection:
- # 2019_616722_0009, dated June 04, 2019,
- # 2018_462600_0006, dated May 25, 2018,
- # 2016_356618_0024, dated January 27, 2017. (500)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 24th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nital Sheth

Service Area Office /
Bureau régional de services : Toronto Service Area Office